I. PURPOSE

A. To ensure high quality patient care and mitigate APOD instances, ED medical personnel and EMS personnel shall collaboratively and cooperatively work to ensure a safe, efficient, timely, and seamless ambulance patient transfer of care.

B. To establish standards and best practices to mitigate ambulance patient offload delays to ensure critical emergency medical service resource availability. These standards and procedures are essential to public safety.

II. AUTHORITY:

Health and Safety Code, Division 2.5, Sections 1797.52, 1797.120 *et seq.*, 1797.218, 1797.220, 1797.225, 1797.252, 1798, 1798.170; California Code of Regulations, Title 22, Division 9, Sections 100063, 100106, 100146, 100170, 100404.

III. DEFINITION(S)

Ambulance Arrival at the Emergency Department (ED): The time the ambulance stops at the location outside the hospital ED where the patient will be unloaded from the ambulance.

Ambulance Patient Offload Time (APOT): The interval between the arrival of an ambulance patient at an emergency department and the time that the patient is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for care of the patient.

Ambulance Patient Offload Time (APOT) Standard: Receiving hospitals have a responsibility to ensure policies and processes are in place that facilitates the rapid and appropriate transfer of patient care from EMS personnel to the ED medical personnel within 30 minutes of arrival at the ED.[1]

[1] The measurement and reporting of this standard is defined in County EMS Policy S-610.

Ambulance Patient Offload Delay (APOD): The occurrence of a patient remaining on the ambulance gurney and/or the emergency department has not assumed responsibility for patient care beyond the LEMSA-approved APOT standard (synonymous with non-standard patient offload time).

Emergency Department Medical Personnel: An ED physician, mid-level practitioner (e.g., Physician Assistant, Nurse Practitioner) or Registered Nurse (RN).

EMS Personnel: EMTs, AEMTs, and/or paramedics responsible for out of hospital patient care and transport consistent with the scope of practice as authorized by their level of credentialing.

Transfer of Care: The transition of patient care responsibility from EMS personnel to receiving hospital ED medical personnel.

Verbal Patient Report: The face-to-face verbal exchange of key patient information between EMS personnel and ED medical personnel provided that is presumed to indicate transfer of patient care.

Written EMS Report: The written report supplied to ED medical personnel that details patient assessment and care that was provided by EMS personnel.

IV. POLICY

A. In support of high quality, patient-centered care, EMS personnel and ED medical personnel shall ensure there is no interruption in patient care while awaiting transfer of care.

B. All patient care by EMS personnel shall be documented according to CoSD EMS policies.

C. The EMS-to-ED transfer requires a patient-centered approach by patient caregivers, including collaboration on key assignments and quality communication. Responsibilities of receiving hospital ED medical personnel and EMS personnel to mitigate extended APOT are listed below.
   1. ED medical personnel shall:
      a. Acknowledge ambulance patient arrival promptly
      b. Upon ambulance patient arrival, provide a visual or rapid assessment
      c. Receive verbal patient report as soon as possible, and
      d. Determine the assigned patient treatment area assignment with resources appropriate to manage the patient's condition to streamline transfer of care.
   2. Upon arrival at ED, EMS personnel shall:

   a. Present to the customary ambulance receiving area for a triage assessment by assigned ED medical personnel (e.g., triage or charge nurse)
   b. Continue to actively assess the patient and document vital signs and treatment in the electronic patient care record
   c. Provide a verbal patient report to assigned ED medical personnel
   d. Transfer patient to hospital equipment, as directed by ED medical personnel for routine transfer of care, and
   e. Complete the transfer of care within 30 minutes of arrival at the ED.
3. If unable to promptly transfer care and offload patient, ED medical personnel shall:
   a. Provide a safe area in the ED within direct sight of ED medical personnel where the EMS personnel can temporarily wait while patient remains on the ambulance gurney
   b. Inform the ambulance transport crew of the anticipated time for the offload of the patient.
4. For anticipated APOT greater than 30 minutes, EMS personal shall:
   a. Monitor for any patient condition changes or other situations that may arise where additional care is required. EMS personnel shall immediately notify appropriate ED medical personnel
   b. Notify agency supervisors of anticipated APOD status
   c. EMS supervisors shall monitor and support EMS personnel during APOD situations
   d. Agency supervisors should contact ED supervisory staff to communicate the need to release EMS personnel.
5. For anticipated APOT greater than 30 minutes, ED medical personnel shall:
   a. Provide information to the EMS personnel and agency supervisor regarding the steps that are being taken by the hospital to resolve the delay
   b. Notify the Nursing Supervisor/Administrator on Duty that the ED is experiencing extended APOT and request assistance with patient throughput challenges.
6. During APOD situations, EMS personnel shall not be required to monitor patients awaiting transfer of care:
   a. In unprotected/unsheltered areas outside of a receiving ED
      OR
   b. Outside of the facility, in a parked ambulance, without a clear need for communicable disease isolation or other safety concerns.

V. TREATMENT ON THE EMS GURNEY GUIDANCE

A. Emergency healthcare providers share the common goal of providing high quality and timely patient care, both in the field and within the hospital ED. To ensure appropriate and timely patient care, these principles shall be maintained:

1. Patients on the EMS gurney may be directed to a "pit stop" and then be moved by EMS personnel to a specific location (e.g., immediate lab draw for a stroke code and then directed to an open CT table)
   a. Patients on the EMS gurney may be directed to areas for performance of time-sensitive diagnostic studies located outside of the traditional ED (examples include CT or other imaging for emergent trauma, stroke codes, or acute traumatic bleeds)
   b. Once the patient is off the EMS gurney for diagnostic studies, transfer of care to the hospital personnel is complete
2. Critical patient assessments may be performed on the EMS gurney to ensure patients are routed to the appropriate specialty care destination, e.g., 12-lead EKGs to determine need to immediately direct the patient to a cardiac cath lab
3. Time-critical labs may be drawn from a patient on an EMS gurney, e.g., labs for stroke code, STEMI
   a. Intake labs ordered solely to speed throughput may not be performed while the patient is on the EMS gurney
4. EMS personnel should not transport patients to radiology for non-emergent imaging, nor should portable imaging be performed on the ambulance gurney
5. EMS personnel may continue Standing Order treatments for 30 minutes after ED arrival while awaiting transfer of care. The goal is to maintain EMS/Hospital continuity of care with a patient-centered focus
   a. EMS personnel will abide by existing scopes of practice. EMS personnel shall not be required to, or responsible for, monitor patients receiving treatments outside of their respective scopes of practice, e.g., antibiotics and other medications or other procedures not authorized by the State of California or the County of San Diego
   b. If more than 30 minutes have elapsed after ED arrival, transfer of care should be completed prior to hospital personnel-initiated treatments, even if these interventions are within the applicable EMS scopes of practice
   c. If the patient's needs are unable to be met by ED medical personnel after a 30-minute APOT, EMS personnel may continue Standing Order treatments, as needed, to maintain therapeutic effect and high-quality patient care. If this occurs, these cases shall be referred for QA/QI, including for hospital follow-up and education

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VI. APOD MITIGATION STRATEGIES

A. Licensed general acute care hospitals with EDs should implement policies and practices to reduce patient offload times. Focus areas, including at the intake, admission, and discharge phases, have been shown to reduce APOD and should be considered. Facility-based ambulance patient offload time reduction protocols should include activating the hospital's surge

plan, enhanced general hospital coordination with the impacted ED, transferring patients to other hospitals, suspending elective admissions, streamlined patient discharge processes, using alternate care sites, increasing supplies, improving triage and transfer systems, and additional staffing.

B. When expecting or experiencing an APOD situation, EMS personnel may implement the following options as potential mitigation strategies, when appropriate. In all situations, a patient-centered, collaborative focus is essential.

C. **Offload to Waiting Area Option**
   1. If the APOT estimate is more than 30 minutes, and the patient meets ALL Offload to Waiting Area criteria listed below, EMS personnel shall:
      a. Inform the appropriate ED medical personnel (e.g., charge nurse) that the patient will be immediately offloaded into the waiting area
      b. Provide a transfer of care report to the appropriate ED medical personnel (e.g., triage nurse)
      c. Document the location in the ED Waiting Area where the patient was offloaded.
   2. Offload to Waiting Area Criteria:
      Prehospital and hospital must confirm that all the following criteria are met:
      a. Anticipated APOT is more than 30 minutes
      b. Patient must be ≥18 years or accompanied by a parent/caregiver if over 18 years of age
      c. Normal mental status (GCS 15 and oriented to person, place, time, and event)
      d. Normal vital signs for adults (or age-appropriate vital signs for pediatrics)
         1) SBP ≥ 90 mm
         2) HR 60-100
         3) RR 12-20
         4) SpO2 ≥ 94% on room air (sustained measure, including on exertion)
      e. Ambulatory with steady gait without assistance (as appropriate for age)
         1) OR, for limited mobility patients, able to sit safely in wheelchair, if hospital staff available to provide ambulatory assistance
      f. Not suicidal
      g. Not on an involuntary hold, conservatorship, or when safety monitoring indicated
      h. No suspicion of acute substance ingestion or overdose
      i. No chest pain, syncope, or acute neurologic symptoms (e.g., focal weakness, dizziness, vertigo, imbalance)
      j. No ALS medications were administered in the field, including fluid boluses
      k. No indication for ongoing monitoring or anticipation of repeat treatments administered in the field

3. EMS personnel *may* transfer patients to waiting area at any time, as directed by ED medical personnel.

D. **EMS Offload Monitoring Team Option**

1. In situations where an EMS crew is unable to transfer patient care to the receiving ED medical personnel within the APOT standard, and to facilitate EMS field operations, the EMS Offload Monitoring Team Option may be deployed. The EMS Offload Monitoring Team assigns each individual agency EMS personnel (EMT, AEMT, or Paramedic) to observe up to 4 patients while awaiting patient offload to receiving facility equipment. This option may be considered when:
   a. EMS personnel APOT estimate more than 30 minutes
      AND
   b. The patient does not meet Offload to Waiting Area Option criteria
2. EMS Offload Monitoring Team Practices
   EMS agencies anticipating an EMS Offload Monitoring Team deployment shall assign an on-site supervisor to:
   a. Support patient-centered care
   b. Act as a coordinator and liaison with ED medical personnel
   c. Identify the EMS Offload Monitoring Team personnel to monitor patients awaiting transfer of care to ED medical personnel
   d. Identify personnel who may be released to accept other emergency calls
   e. Ensure patient and crew accountability, in conjunction with ED medical personnel
   f. Identify, in coordination with ED medical personnel, suitable EMS Offload Monitoring Team staging locations with an expectation for patient safety, communication, and an ability to rapidly receive ED care, as needed
   g. Authorize the placement of temporary cots, chairs, or wheelchairs to house EMS Offload Monitoring Team patients
   h. Request additional EMS agency personnel to assume EMS Offload Monitoring Team roles to ensure appropriate EMS system capacity, as needed
3. EMS providers shall not be required to monitor patients with known or suspected care and monitoring needs outside of the individual EMS provider's credentialed scope of practice
   a. EMTs may not be assigned to monitor EMS patients requiring ongoing cardiac monitoring or have received prehospital paramedic-level care unless specifically authorized for a Patient Centered Care Modification for field transport prior to ED arrival
4. Receiving EDs should provide appropriate equipment suitable for temporary patient offload placement, including gurneys, cots, chairs, and wheelchairs for EMS Offload Monitoring Team use

   a. Agencies are encouraged to work with receiving facilities to identify appropriate gurneys, cots, or other equipment for Offload Monitoring Team use. This may include staged agency-owned equipment for Offload Monitoring Team use
5. Document the transfer of care, as defined in County EMS Policy S-610

VII. REFERENCES

A. Centers for Medicare and Medicaid (CMMS) Survey and Certification Group, *EMTALA - "Parking" of Emergency Medical Service Patients in Hospitals (S&C-06-21)*, 2006.
B. Centers for Medicare and Medicaid (CMMS) Survey and Certification Group, EMTALA Issues Related to Emergency Transport Services (S&C-07-20), 2007
C. California Hospital Association, Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department, 2014
D. California Department of Public Health All Facilities Letter, EMTALA – “Parking” of Emergency Medical Service Patients in Hospitals (AFL 07-04), 2007
E. California EMS Authority, *Ambulance Patient Offload Delays*, 2020